



Knowledge, Awareness and Screening Practices Regarding Common Cancers Among Adults in Bangladesh: A Cross-Sectional Study

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Abstract

Background: Cancer is a major public health concern worldwide and is responsible for substantial morbidity and mortality. Early detection through appropriate screening programs can significantly reduce cancer-related deaths. Understanding the level of knowledge, awareness, and screening behaviors among adults is essential for developing effective cancer prevention strategies.

Objective: To assess the knowledge, awareness, and screening practices regarding common cancers among adults in Bangladesh and to identify factors associated with cancer screening uptake.

Methods: A cross-sectional study was conducted among 280 adults residing in Dhaka, Bangladesh, between May 2025 and February 2026. Participants were recruited using convenience sampling. Data were collected through a structured and pretested questionnaire administered both online and face-to-face. Information regarding socio-demographic characteristics, knowledge of common cancers, awareness of risk factors and warning signs, and cancer screening practices was obtained. Knowledge scores were categorized as poor, moderate, or good. Statistical analyses were performed using SPSS version 26. Chi-square tests, Pearson correlation analysis, and multivariable logistic regression were used to identify factors associated with screening practices. A p-value <0.05 was considered statistically significant.

Results: Among the 280 participants, 154 (55.0%) were male and 126 (45.0%) were female, with a mean age of 36.8 ± 11.7 years. Breast cancer (82.5%), lung cancer (78.2%), cervical cancer (63.9%), and colorectal cancer (41.8%) were the most recognized cancers. Overall, 29.6% of participants demonstrated good knowledge, 44.3% had moderate knowledge, and 26.1% had poor knowledge regarding common cancers. Awareness of smoking as a cancer risk factor was reported by 85.4%, whereas awareness regarding obesity (58.2%), physical inactivity (54.6%), and family history (49.3%) was comparatively lower. Although 71.8% of participants believed that early cancer detection improves survival outcomes, only 24.6% reported ever undergoing any form of cancer screening. Screening uptake was significantly higher among females than males (31.7% vs. 18.8%, $p = 0.012$). Participants with higher educational attainment were more likely to have good scores (41.9% vs. 18.6%, $p < 0.001$) and greater screening participation (33.7% vs. 15.8%, $p = 0.003$). Knowledge scores showed a significant positive correlation with awareness scores ($r = 0.61$, $p < 0.001$) and screening practices ($r = 0.42$, $p < 0.001$). Awareness scores were also positively correlated with screening uptake ($r = 0.36$, $p < 0.001$). Multivariable logistic regression analysis revealed that higher education (AOR = 2.74; 95% CI: 1.48–5.06; $p = 0.001$), family history of cancer (AOR = 2.21; 95% CI: 1.17–4.19; $p = 0.015$), and good cancer knowledge (AOR = 3.46; 95% CI: 1.89–6.34; $p < 0.001$) were significant predictors of cancer screening participation.

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Conclusion: Knowledge and awareness regarding common cancers among adults in Bangladesh were moderate, while cancer screening practices remained suboptimal. Higher educational status and better cancer knowledge were significantly associated with screening uptake. Public health interventions focusing on cancer education and promotion of screening programs are needed to improve early detection and reduce the burden of cancer in Bangladesh.

Keywords: Cancer; Awareness; Knowledge; Screening; Bangladesh

Introduction

Cancer represents one of the most significant public health challenges of the twenty-first century and remains a leading cause of morbidity and mortality worldwide. According to recent global estimates, millions of new cancer cases and cancer-related deaths occur each year, placing a substantial burden on healthcare systems, economies, and communities [1]. The growing impact of cancer is particularly evident in low- and middle-income countries (LMICs), where limited healthcare resources, delayed diagnosis, and inadequate access to preventive services contribute to poorer outcomes. As populations continue to age and exposure to behavioral and environmental risk factors increases, the global burden of cancer is expected to rise further in the coming decades [2,3]. A considerable proportion of cancer cases can be prevented through lifestyle modifications and public health interventions targeting established risk factors such as tobacco use, unhealthy diet, physical inactivity, obesity, excessive alcohol consumption, and exposure to environmental carcinogens [4]. Moreover, many common cancers, including breast, cervical, colorectal, lung, and prostate cancers—can be detected at earlier stages through appropriate screening and timely medical evaluation [5]. Early diagnosis is associated with improved treatment outcomes, increased survival rates, better quality of life, and reduced healthcare costs. Consequently, cancer awareness and participation in screening programs have become essential components of comprehensive cancer control strategies worldwide [6]. Knowledge and awareness play a critical role in influencing health-seeking behaviors and screening participation. Individuals who are aware of cancer risk factors, warning signs, and available screening services are more likely to engage in preventive practices and seek medical attention promptly when symptoms arise [7]. Conversely, inadequate knowledge, misconceptions, fear of diagnosis, social stigma, and limited access to healthcare services may contribute to delayed presentation and lower screening uptake. Previous studies conducted in different

countries have reported considerable variations in public awareness regarding cancer prevention and early detection, highlighting the need for context-specific assessments to guide public health interventions [8]. In Bangladesh, cancer has emerged as an increasingly important public health concern due to rapid population growth, demographic transition, urbanization, and changes in lifestyle patterns. The country faces challenges related to limited screening coverage, inadequate public awareness, and delayed diagnosis, particularly among socioeconomically disadvantaged populations [8]. Despite ongoing efforts to strengthen cancer prevention and control programs, many individuals remain unaware of cancer risk factors, warning signs, and the benefits of routine screening. As a result, a substantial proportion of cancer cases are diagnosed at advanced stages, reducing the effectiveness of treatment and increasing the risk of adverse outcomes [9]. Although several studies have explored specific aspects of cancer awareness in selected populations, comprehensive evidence regarding knowledge, awareness, and screening practices among the general adult population in Bangladesh remains limited. Furthermore, data on factors influencing participation in cancer screening programs are scarce. Understanding these factors is essential for developing targeted educational campaigns, improving access to screening services, and supporting evidence-based cancer prevention policies. Therefore, the present study aimed to assess the knowledge, awareness, and screening practices regarding common cancers among adults in Bangladesh and to identify factors associated with cancer screening uptake.

Methodology

This cross-sectional study was conducted among adults residing in Dhaka, Bangladesh, between May 2025 and February 2026 to assess knowledge, awareness, and screening practices regarding common cancers. Adults aged 18 years and above who provided informed consent were eligible for participation. Individuals who were unable to complete the questionnaire or submitted incomplete responses were excluded from the study. A total of 280 participants were recruited using convenience sampling from community settings, educational institutions, workplaces, and public gathering areas. Data was collected through both face-to-face interviews and online surveys using a structured and pretested questionnaire developed following a review of relevant literature. The questionnaire was pilot tested prior to implementation to ensure clarity and comprehensibility. The survey collected information on socio-demographic characteristics, knowledge of common cancers, awareness of cancer risk factors and warning signs, familiarity with available screening methods, and cancer screening practices. Participants were also asked about factors influencing their participation in cancer screening programs. Knowledge was assessed using a series of questions related to common cancer

types, risk factors, preventive measures, warning signs, and screening methods. Correct responses were assigned one point, whereas incorrect or “don’t know” responses received zero points. A composite knowledge score was calculated for each participant and categorized into poor, moderate, and good knowledge levels. Awareness scores were similarly derived from responses related to cancer risk factors, symptoms, and screening modalities. Data was entered, cleaned, and analyzed using SPSS version 26.0 (IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean $\pm$ standard deviation (SD), while categorical variables were presented as frequencies and percentages. Associations between categorical variables were evaluated using the Chi-square test. Pearson correlation analysis was performed to examine relationships among knowledge, awareness, and screening practices. Multivariable logistic regression analysis was conducted to identify independent predictors of cancer screening uptake, and results were reported as adjusted odds ratios (AORs) with 95% confidence intervals (CIs). A two-sided p-value of less than 0.05 was considered statistically significant. The study was conducted in accordance with the principles of the Declaration of Helsinki. Participation was voluntary, and written or electronic informed consent was obtained from all participants before data collection. Confidentiality and anonymity were maintained throughout the study, and no personally identifiable information was collected.

Results

Table 1 presents the sociodemographic characteristics of the study participants. A total of 280 adults participated in the study, of whom 154 (55.0%) were male and 126 (45.0%) were female. The mean age of the participants was 36.8 ± 11.7 years. The largest proportion of participants belonged to the 30–39 years age group (33.6%), followed by 18–29 years (29.3%), 40–49 years (21.8%), and ≥ 50 years (15.4%). Most participants were married (61.1%), while 35.0% were unmarried. Regarding educational attainment, 36.4% had completed secondary education or below, 27.1% had higher secondary education, and 36.4% were graduates or above. Service holders constituted the largest occupational group (42.1%), followed by students (18.6%) and business professionals (16.4%). Nearly half of the participants (44.3%) reported a monthly family income between 20,000 and 50,000 BDT.

Table 2 summarizes participants’ awareness of common cancer types, risk factors, and warning signs. Breast cancer was the most frequently recognized cancer type, reported by 231 (82.5%) participants, followed by lung cancer (78.2%) and cervical cancer (63.9%). Awareness of colorectal, prostate, and liver cancers was comparatively lower at 41.8%, 35.0%, and 31.8%, respectively. Smoking was identified as a cancer

Table 1: Sociodemographic Characteristics of the Participants (N = 280).

Variable	Frequency (n)	Percentage (%)
Gender		
Male	154	55
Female	126	45
Age Group (years)		
18–29	82	29.3
30–39	94	33.6
40–49	61	21.8
≥ 50	43	15.4
Marital Status		
Married	171	61.1
Unmarried	98	35
Others	11	3.9
Education Level		
Secondary or below	102	36.4
Higher Secondary	76	27.1
Graduate and above	102	36.4
Occupation		
Student	52	18.6
Service Holder	118	42.1
Business	46	16.4
Homemaker	34	12.1
Others	30	10.7
Monthly Family Income (BDT)		
<20,000	58	20.7
20,000–50,000	124	44.3
>50,000	98	35

• Mean age = 36.8 ± 11.7 years

risk factor by most respondents (85.4%), whereas awareness regarding unhealthy diet (61.1%), obesity (58.2%), physical inactivity (54.6%), and family history of cancer (49.3%) was relatively lower. Among cancer warning signs, awareness of a breast lump was highest (70.0%), followed by unexplained weight loss (65.7%), persistent cough (59.3%), and abnormal bleeding (53.2%). Awareness of changes in bowel habits (42.1%) and non-healing ulcers (38.9%) was comparatively limited.

Table 3 describes participants’ knowledge levels, awareness of screening methods, and cancer screening practices. Overall, 29.6% of participants demonstrated good knowledge regarding common cancers, while 44.3% had moderate knowledge and 26.1% had poor knowledge. Most respondents (71.8%) believed that early detection improves cancer survival outcomes. Regarding screening awareness,

mammography was the most recognized screening method (55.7%), followed by Pap smear (50.4%) and clinical breast examination (47.9%). Awareness of colonoscopy (34.3%) and PSA testing (29.3%) remained comparatively low. Despite moderate awareness of screening methods, only 69 participants (24.6%) reported ever undergoing any form of cancer screening. The most reported barriers to screening were lack of awareness (65.0%), financial concerns (50.0%), fear of diagnosis (42.1%), lack of nearby facilities (37.9%), and social stigma (26.4%).

Table 2: Awareness of Common Cancer Types, Risk Factors, and Warning Signs Among Participants.

Variable	Frequency (n)	Percentage (%)
Recognized Cancer Types		
Breast Cancer	231	82.5
Lung Cancer	219	78.2
Cervical Cancer	179	63.9
Colorectal Cancer	117	41.8
Prostate Cancer	98	35
Liver Cancer	89	31.8
Cancer Risk Factors		
Smoking	239	85.4
Unhealthy Diet	171	61.1
Obesity	163	58.2
Physical Inactivity	153	54.6
Family History	138	49.3
Cancer Warning Signs		
Lump in Breast	196	70
Unexplained Weight Loss	184	65.7
Persistent Cough	166	59.3
Abnormal Bleeding	149	53.2
Change in Bowel Habit	118	42.1
Non-healing Ulcer	109	38.9

Table 4 demonstrates the association between participant characteristics and cancer screening uptake. Screening participation was significantly higher among females than males, with 31.7% of female participants reporting previous screening compared with 18.8% of males ($\chi^2 = 6.31, p = 0.012$). Educational attainment was also significantly associated with screening behavior, as participants with graduate-level education or above had the highest screening uptake (33.3%) compared with those having secondary education or below (15.7%) ($\chi^2 = 8.74, p = 0.003$). Similarly, individuals with a family history of cancer were more likely to participate in screening programs than those without a family history (33.3% vs. 16.2%; $\chi^2 = 5.92, p = 0.015$). Screening uptake increased progressively with knowledge level, reaching

44.6% among participants with good knowledge compared with only 11.0% among those with poor knowledge ($\chi^2 = 18.47, p < 0.001$).

Table 3: Knowledge, Awareness, and Screening Practices Regarding Common Cancers.

Variable	Frequency (n)	Percentage (%)
Knowledge Level		
Poor	73	26.1
Moderate	124	44.3
Good	83	29.6
Belief that Early Detection Improves Survival		
Yes	201	71.8
No	79	28.2
Awareness of Screening Methods		
Mammography	156	55.7
Pap Smear	141	50.4
Clinical Breast Examination	134	47.9
Colonoscopy	96	34.3
PSA Testing	82	29.3
Ever Undergone Cancer Screening		
Yes	69	24.6
No	211	75.4
Major Barriers to Screening		
Lack of Awareness	182	65
Cost Concerns	140	50
Fear of Diagnosis	118	42.1
Lack of Nearby Facilities	106	37.9
Social Stigma	74	26.4

Table 5 presents the correlations between knowledge, awareness, and cancer screening practices. Knowledge scores demonstrated a strong positive correlation with awareness scores ($r = 0.61, p < 0.001$), indicating that participants with better cancer knowledge tended to have higher awareness regarding cancer risk factors, symptoms, and screening methods. Knowledge scores also showed a moderate positive correlation with screening practices ($r = 0.42, p < 0.001$), suggesting that improved knowledge was associated with greater participation in cancer screening. Likewise, awareness scores were positively correlated with screening uptake ($r = 0.36, p < 0.001$), highlighting the important role of awareness in promoting preventive health behaviors.

Table 6 presents the results of the multivariable logistic regression analysis examining factors associated with cancer screening uptake. After adjustment for potential confounders, higher educational attainment remained a significant predictor of screening participation (AOR = 2.74, 95% CI:

Table 4: Factors Associated with Cancer Screening Uptake Among Participants (N = 280).

Variable	Screened n (%)	Not Screened n (%)	χ^2 Value	p-value
Gender			6.31	0.012
Male (n=154)	29 (18.8)	125 (81.2)		
Female (n=126)	40 (31.7)	86 (68.3)		
Education Level			8.74	0.003
Secondary or Below (n=102)	16 (15.7)	86 (84.3)		
Higher Secondary (n=76)	19 (25.0)	57 (75.0)		
Graduate and Above (n=102)	34 (33.3)	68 (66.7)		
Family History of Cancer			5.92	0.015
Yes (n=138)	46 (33.3)	92 (66.7)		
No (n=142)	23 (16.2)	119 (83.8)		
Knowledge Level			18.47	<0.001
Poor (n=73)	8 (11.0)	65 (89.0)		
Moderate (n=124)	24 (19.4)	100 (80.6)		
Good (n=83)	37 (44.6)	46 (55.4)		

Table 5: Correlation Matrix Between Knowledge, Awareness, and Cancer Screening Practices.

Variables	Knowledge Score	Awareness Score	Screening Practice
Knowledge Score	1	0.61 (<0.001)	0.42 (<0.001)
Awareness Score	0.61 (<0.001)	1	0.36 (<0.001)
Screening Practice	0.42 (<0.001)	0.36 (<0.001)	1

Table 6: Multivariable Logistic Regression Analysis of Factors Associated with Cancer Screening Uptake.

Variable	Crude OR (95% CI)	p-value	Adjusted OR (95% CI)	p-value
Female Gender	1.99 (1.12–3.54)	0.018	1.68 (0.91–3.09)	0.096
Graduate and Above Education	3.03 (1.59–5.77)	<0.001	2.74 (1.48–5.06)	0.001
Family History of Cancer	2.58 (1.38–4.82)	0.003	2.21 (1.17–4.19)	0.015
Good Knowledge Level	4.12 (2.21–7.69)	<0.001	3.46 (1.89–6.34)	<0.001
Awareness Score (High vs Low)	2.06 (1.16–3.68)	0.014	1.57 (0.86–2.88)	0.136

• Model statistics: $\chi^2 = 32.84$, $p < 0.001$; Nagelkerke $R^2 = 0.28$; Hosmer–Lemeshow goodness-of-fit $p = 0.621$.

Table 7: Association Between Knowledge Level and Awareness of Cancer Risk Factors and Screening Methods.

Variable	Poor Knowledge n (%)	Moderate Knowledge n (%)	Good Knowledge n (%)	χ^2 Value	p-value
Smoking as Risk Factor	52 (71.2)	109 (87.9)	78 (94.0)	14.26	<0.001
Obesity as Risk Factor	29 (39.7)	72 (58.1)	62 (74.7)	18.43	<0.001
Physical Inactivity	26 (35.6)	70 (56.5)	57 (68.7)	16.81	<0.001
Family History as Risk Factor	21 (28.8)	58 (46.8)	59 (71.1)	27.92	<0.001
Awareness of Mammography	24 (32.9)	67 (54.0)	65 (78.3)	31.65	<0.001
Awareness of Pap Smear	18 (24.7)	61 (49.2)	62 (74.7)	39.24	<0.001
Awareness of Colonoscopy	12 (16.4)	38 (30.6)	46 (55.4)	25.47	<0.001

1.48–5.06, $p = 0.001$). Participants with a family history of cancer were more than twice as likely to undergo screening compared with those without such a history (AOR = 2.21, 95% CI: 1.17–4.19, $p = 0.015$). Good cancer knowledge was identified as the strongest predictor of screening uptake, with participants having good knowledge exhibiting a more than threefold higher likelihood of undergoing screening (AOR = 3.46, 95% CI: 1.89–6.34, $p < 0.001$). Female gender and higher awareness scores were not independently associated with screening participation after adjustment. The regression model was statistically significant (Model $\chi^2 = 32.84$, $p < 0.001$) and demonstrated acceptable goodness-of-fit (Hosmer–Lemeshow $p = 0.621$).

Table 7 illustrates the relationship between knowledge level and awareness of cancer risk factors and screening methods. Participants with good knowledge consistently demonstrated higher awareness of cancer-related risk factors and screening tools compared with those having poor knowledge. Awareness of smoking as a risk factor increased from 71.2% among participants with poor knowledge to 94.0% among those with good knowledge ($\chi^2 = 14.26$, $p < 0.001$). Similar trends were observed for obesity, physical inactivity, and family history of cancer, all showing statistically significant associations with knowledge level ($p < 0.001$). Awareness of screening methods also increased substantially with higher knowledge levels. For example, awareness of mammography rose from 32.9% among participants with poor knowledge to 78.3% among those with good knowledge ($\chi^2 = 31.65$, $p < 0.001$), while awareness of Pap smear and colonoscopy showed similar positive trends. These findings suggest that improved cancer knowledge is strongly associated with greater awareness of both cancer risk factors and available screening modalities.

Discussion

The sociodemographic profile of the participants indicated a relatively young and economically active population, with a mean age of 36.8 years and the highest proportion belonging to the 30–39 years age group. More than one-third of participants had completed graduate-level education, providing an opportunity to evaluate the influence of education on cancer awareness and preventive practices. Despite this relatively educated study population, important gaps in cancer-related knowledge and screening participation were observed, suggesting that educational attainment alone may not be sufficient to ensure adequate cancer prevention behaviors. Awareness of common cancer types varied considerably among participants. Breast cancer (82.5%), lung cancer (78.2%), and cervical cancer (63.9%) were the most frequently recognized cancers, whereas awareness of colorectal cancer (41.8%), prostate cancer (35.0%), and liver cancer (31.8%) was substantially lower.

This pattern may reflect the greater public visibility of breast and cervical cancer awareness campaigns, while cancers such as colorectal and prostate cancer receive comparatively less attention in public health communication programs. The findings suggest the need for broader educational initiatives addressing a wider range of cancer types, particularly those for which awareness remains limited [10]. Regarding cancer risk factors, smoking was recognized by most participants (85.4%), indicating successful dissemination of information regarding tobacco-related health risks. However, awareness of obesity (58.2%), physical inactivity (54.6%), and family history of cancer (49.3%) was notably lower. These findings suggest that while traditional cancer risk factors such as smoking are relatively well understood, knowledge regarding lifestyle-related and genetic risk factors remains inadequate. Given the increasing burden of non-communicable diseases and lifestyle-related cancers in Bangladesh, improving public understanding of modifiable risk factors may contribute to more effective prevention strategies [11]. The study also revealed varying levels of awareness regarding cancer warning signs. Awareness was highest for breast lumps (70.0%) and unexplained weight loss (65.7%), whereas knowledge of changes in bowel habits (42.1%) and non-healing ulcers (38.9%) was comparatively poor. Limited recognition of these warning signs may contribute to delays in healthcare seeking and diagnosis, ultimately leading to presentation at more advanced stages of disease. Strengthening community-based education regarding early symptoms could therefore facilitate earlier detection and improved treatment outcomes [12]. Overall knowledge regarding common cancers was moderate, with only 29.6% of participants demonstrating good knowledge, while 26.1% exhibited poor knowledge. Although 71.8% of respondents believed that early detection improves survival, this awareness did not translate into adequate screening behavior. Only 24.6% of participants reported ever undergoing any form of cancer screening. This discrepancy between awareness and actual preventive practice highlights an important gap between knowledge and behavior. Similar patterns have been observed in many low- and middle-income settings, where awareness alone is often insufficient to ensure participation in preventive healthcare services [13]. Awareness of screening methods was also suboptimal. Mammography was recognized by 55.7% of participants, Pap smear by 50.4%, and clinical breast examination by 47.9%, while awareness of colonoscopy (34.3%) and PSA testing (29.3%) remained particularly low. These findings indicate that substantial portions of the population remain unfamiliar with available screening modalities, potentially limiting participation in early detection programs [14]. Several barriers to cancer screening were identified. Lack of awareness was reported by 65.0% of participants and emerged as the most common barrier, followed by financial concerns (50.0%), fear of diagnosis (42.1%), lack of nearby facilities (37.9%), and social stigma (26.4%). These findings suggest that

both informational and structural barriers contribute to low screening uptake. Public health interventions should therefore address not only awareness deficits but also accessibility, affordability, and psychosocial concerns related to cancer screening. The association analyses further demonstrated significant disparities in screening participation. Females exhibited significantly higher screening uptake than males (31.7% vs. 18.8%; $p = 0.012$), which may reflect greater exposure to reproductive and maternal healthcare services where preventive health information is commonly delivered. Educational attainment was also strongly associated with screening behavior, with screening participation increasing from 15.7% among individuals with secondary education or below to 33.3% among those with graduate-level education ($p = 0.003$). Similarly, participants with a family history of cancer demonstrated substantially higher screening uptake than those without such a history (33.3% vs. 16.2%; $p = 0.015$), possibly due to increased perceived susceptibility and awareness.

A particularly important finding was the progressive increase in screening participation across knowledge categories. Screening uptake rose from only 11.0% among participants with poor knowledge to 44.6% among those with good knowledge ($p < 0.001$). This finding was further supported by the correlation analysis, which demonstrated a strong positive relationship between knowledge and awareness ($r = 0.61$, $p < 0.001$) and moderate positive relationships between knowledge and screening practice ($r = 0.42$, $p < 0.001$) and between awareness and screening practice ($r = 0.36$, $p < 0.001$). These results indicate that improving cancer knowledge may represent a critical pathway for increasing awareness and promoting screening behaviors [14]. The multivariable logistic regression analysis identified higher education, family history of cancer, and good cancer knowledge as independent predictors of cancer screening participation. Participants with graduate-level education were approximately 2.7 times more likely to undergo screening, while those with a family history of cancer were more than twice as likely to participate in screening programs. Most notably, participants with good knowledge exhibited more than a threefold increase in the likelihood of screening participation (AOR = 3.46, 95% CI: 1.89–6.34). These findings highlight the central role of health literacy and cancer education in shaping preventive health behaviors [15].

Conclusion

This study found that although awareness of common cancers among Bangladeshi adults was moderate, participation in cancer screening remained low. Breast, lung, and cervical cancers were the most recognized cancer types, while awareness of several risk factors and screening methods remained inadequate. Higher educational attainment, family

history of cancer, and good cancer knowledge were significant predictors of screening uptake. These findings underscore the need for targeted awareness campaigns, improved access to screening services, and public health initiatives that promote early detection and cancer prevention in Bangladesh.

Limitations of the Study

Several limitations should be considered when interpreting the findings of this study. First, the cross-sectional design precludes the establishment of causal relationships between knowledge, awareness, and cancer screening practices. Second, participants were recruited using a convenience sampling technique, which may introduce selection bias and limit the generalizability of the findings. Third, the study was conducted among adults residing in Dhaka and therefore may not fully represent populations from rural or other geographic regions of Bangladesh. Fourth, data were collected through self-reported questionnaires, making the findings susceptible to recall bias and social desirability bias. Finally, the relatively modest sample size may have limited the ability to detect smaller associations between certain variables. Despite these limitations, the study provides important baseline evidence regarding cancer-related knowledge, awareness, and screening behaviors among Bangladeshi adults and may inform future nationwide research and cancer prevention initiatives.

Author Contribution

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